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What Enhancement Techniques Suggest about the Good Death

By Aske Juul Lassen & Michael Andersen

Abstract

The contemporary increase in life expectancy in Western countries has led to an intensified focus on good ageing processes as a way to manage ageing populations. We argue that while qualifications of the ageing process such as active and healthy ageing endeavour to compress morbidity through enhancement techniques, the idea of the good old age also implicitly tells a tale about the 'good' death. We explore how current discourses depict old age as an active, engaged and independent life phase and construct a specific idea of the good death as one that is quick and painless. By engaging with literature on ageing, death and enhancement technologies as well as current Danish healthcare initiatives, we examine the paradoxical, contemporary notion of death as natural, quick, painless and controllable. Danish rehabilitation programmes are provided as an example of specific enhancement techniques that through motivation and physical activity orchestrate the good death in a body that has been as healthy as possible for as long as possible. However, when such techniques become a moral injunction rather than a choice, questions arise concerning the relationship between autonomy and death. We argue that the discursive construction of the good death happens in tandem with enhancement techniques that postpone death, and that this postponement of death has increasingly become more of an imperative than an autonomous decision.

Keywords: death, ageing, autonomy, enhancement, rehabilitation

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Introduction

*'You see, of course, if you're not a dunce,
How it went to pieces all at once, -
All at once, and nothing first, -
Just as bubbles do when they burst.'*

(*'Wonderful One Hoss Shay'*, Oliver Wendell Holmes)

When 75-year-old British nurse Gill Pharaoh committed suicide in a clinic in Switzerland in the summer of 2015, her death nuanced an ongoing debate about the good death. While some organisations that advocate for the elderly have argued for less rigid laws regarding assistance to end life when facing inevitable, painful death, Gill Pharaoh's suicide stood out because she was not facing physical suffering in her immediate future. Rather, she was experiencing a proliferation of 'trivial' pains and irritations that come with old age and committed suicide preventively. She did not wish to become a burden on others, wanted to maintain autonomy, and did not want to be remembered as an old lady¹. We explore in this article how the current Western discourses on autonomy and health in old age construct a specific idea of the good death.

The contemporary increase in average life expectancy and increasingly ageing populations has led to a proliferation of bodily and medical technologies targeted at old age. While medical, preventive and rehabilitative programmes aimed at the elderly disclose an increasing focus on 'good' ageing processes that venture to compress the period of morbidity and potentially postpone old age, these programmes also tell a tale about death. Sociologists Moreira and Palladino (2008) have shown how the biogerontological debate about the nature of death says a lot about how the 'politics of life itself' (Rose 2007) is played out. However, we reverse this strategy here and explore what medical technologies and health intervention programmes say about death. With this, we wish to stress the close relation between discourses and policies on life and on death, and how both phenomena are objects of biopolitical interventions that aim to stretch and enhance the limits of human capacity. The article argues that the good death – understood as a normative and discursive phenomena – is shaped through enhancement techniques that target old age.

The focus on enhancement and old age relates to ongoing research of one of the authors of this article who focuses on the formation of the good life in old age, and the effects of current policy programmes that emphasise healthy, active and successful ageing (Lassen 2014a). In these policy programmes, old age is not merely the last step before death; it is a phase of life wherein people are encouraged to

participate actively, engage in their community and realise their full potential (e.g. WHO 2002; EC 2011). This approach is beneficial both for the national economies of the European welfare states, as well as for the quality of life of older citizens (Walker 2002).

As has been noted by numerous anthropologists, the boundaries between life and death have always been contested; with new kinds of technologies the process of dying and the timing of death is constantly altered (Scheper-Hughes 2002; Franklin & Lock 2003; Sharp 2007). With the emergence of a long old age as the new normal in Western societies, death is being pushed further into the darkest and most remote corner of the life phase. We question in this article what becomes of death when old age is increasingly formed as a period of engagement, participation and activity. We respond to these volatile questions by exploring some contemporary developments within the healthcare sector of European welfare states and their handling of ageing populations by drawing on examples from Denmark in particular. Our focus is on how enhancement techniques facilitate and shape not only the 'good' old age, but also the 'good' death.

With this focus on enhancement and death we also draw on a body of American anthropological literature that explores how enhancement technologies, i.e. pacemakers, cochlear implants, or breathing ventilators, stretch the limits of human capacity. We extend this attention to enhancement techniques, i.e. enhancement as a phenomena obtained through bodily techniques, which can (but do not necessarily) include the use of technology, such as exercise and diets. Contemporary Danish rehabilitation programmes are examples of such techniques, wherein human enhancement is obtainable through motivation and physical activity, which is sometimes supported by technology. The quest for human enhancement has become both an individual as well as a communal endeavour and to remain active and independent has increasingly become a moral issue, due to the emphasis on individual responsibility in maintaining a healthy body and how this forms the economy of the healthcare sector and cultural understandings of proper conduct. While these issues have been widely criticised (e.g. Holstein & Minkler 2003; Rudman 2006; Lassen & Moreira 2014), this article argues that this emphasis on remaining independent has not just altered the good life in old age. The good death has become one that is as quick and easy as possible.

We limit this article to a discussion of the relation between enhancement technologies and the good death in a Western context, based on a document analysis of Danish policies on homecare and rehabilitation and a literature review of existing social science studies of death and dying. While these policies represent the empirical examples and are incorporated to the effect of showcasing how the discourse on the good death and enhancement technologies have become intertwined, the scope of this article is not solely Danish. Policies on old age in most

Western countries resemble each other regarding the focus on independence and an active old age due to international policy programs, i.e. active and healthy ageing in the EU and WHO. The Danish policies should be seen as examples of how an international focus on independence in death and old age plays out locally (for a detailed description of how this focus on independence is played out in European old age policies see Rostgaard et al. 2011).

We begin by analysing the link between the good life and the good death and how this is associated with a particular view on the good old age. Following this, we examine how this association produces a range of paradoxes. We then point to the way these paradoxes relate to the way old age and disability have been transformed in the 20th century, by using examples from disability studies and social gerontology highlighting autonomy. In the final part of the article, we approach how this autonomy is coupled with rehabilitation practices among older people and more specifically with enhancement techniques that are increasingly becoming a part of Danish old age policies. By doing so, we question what enhancement techniques actually do to the question of autonomy when these techniques increasingly become a moral injunction rather than a choice. Coupled with an analysis on the utilisation of enhancement techniques by the Danish welfare state, we argue that the discursive construction of the good death happens in tandem with enhancement techniques that postpone death, and make the choice of postponement more of an imperative than an autonomous decision.

From the good life to the good death

Within Danish ethnology, the good life is framed as a central object of study. As ethnologist Tine Damsholt stated recently, the concept of the good life in Danish ethnology has its roots in the work of American anthropologist Robert Redfield and his descriptions of ‘the peasant view of the good life’ (1956). The good life is a normative as well as an analytic and situated concept (Damsholt 2015). Whereas the normative good life is shaped around a series of injunctions (physical activity, industriousness, diets etc.), the analytic good life is a tool to investigate different versions of the good life across classes and cultures. The situated good life scrutinises the way ethnology and related disciplines participate in the formulations of the good life based on situated knowledge. We address here how the end of life – death – is just as politically, historically and culturally formed as life, and how the good death contains some of the same characteristics as the good life.

Central to all the different approaches to the good life outlined above is the idea that life is a target for political intervention. In this line of thought, the practices, perceptions, infrastructures and biological processes of life are not exterior to politics, but are formed through the political interventions in different spheres of

life, i.e., by and through education, hygiene and healthcare systems. Often referred to as biopolitics, this idea of the politics of life is linked to a shift in the political gaze in the 18th and 19th centuries from a focus on territory to one of healthy and strong populations (Foucault 1994). Whereas the peasant view of the good life described by Robert Redfield is formed through the yearly processes of agricultural production, this has been replaced by political expectations, economic restrictions and moral obligations.

In recent years there has been an increased academic interest in the way old age has become a focus of biopolitical intervention (Neilson 2003; Otto 2013). When more and more people live longer, the way of life in old age becomes charged with cultural and political expectations. Hence, the good life not only refers to specific conduct during childhood and adulthood, but also to the way people live when they are old (see Lassen 2014a). It is no longer acceptable for old people to relax, enjoy their golden years and sit on their couches once they have reached retirement (Venn & Arber 2011; Lassen 2014b). Instead, gerontological and political programmes of active, healthy and successful ageing suggest that life after retirement today is a period of new opportunities for self-realisation, self-care, experiences and optimisation (Alftberg & Lundin 2012; Bülow 2014; Lassen & Moreira 2014). As a normative concept, the good life in old age refers to active and healthy conduct of one's life, where the focus is less on the decline that comes with old age than on the opportunities that come with it. However, inscribed into this focus on activity and health is a counteraction against decline and frailty. One should engage actively in life in old age because the alternative is decline and frailty. This calls for a responsabilised self, i.e. a self that internalises specific external demands concerning his/her life, who engages in an active old age in order to stay healthy and independent of welfare services for as long as possible – ideally until death.

As such, the normative good life in old age is a healthy life that counteracts decline. But decline is always implicitly present as the result of the failure to comply with the good life. And, again implicitly, at the end of decline comes death. With the circumscription of old age into a period of activity and a healthy lifestyle, decline and death can be postponed. The question then becomes whether this postponement erases decline and death discursively, or rearranges them to form new ideals of declining and dying.

As the introductory quote by Oliver Wendell Holmes alludes to, we have identified a specific way of talking about the good death as a death that is quick, painless and occurs all at once – a kind of death that should ideally occur at the end of a long life. This idea of the good death is founded upon biological theories such as compression of morbidity (Fries 1980) – which endeavours to facilitate lifestyles that cause as little experience of morbidity as possible prior to a death that occurs as close to the maximum life span as possible – and on enhancement techniques

that create healthy and resilient bodies that can go (or perhaps run would be more suitable in this analogy) until they ‘burst’.

The paradoxes of autonomy and death

The autonomous individual is a responsible individual who is able to make decisions about his or her healthcare and treatment. Theories such as compression of morbidity form an entrepreneurial and responsabilised self to secure one’s own health by making healthy lifestyle choices (Dillon & Guerrero 2008). As Kaufman has shown, when approaching death this responsabilised self is faced with a very limited form of autonomy and is only able to choose between the few treatment possibilities that are determined by hospital regulations (2005). While patient organisations have fought for the right of patients to choose between different death trajectories, death is medicalised to the extent that healthcare structures in large part determine death trajectories (Glaser & Strauss 1968; Kaufman 2005). As such, there seems to be a paradox between the autonomous death that many people strive for and the limited autonomy that death in hospitals (where most deaths occur in the Western world) has to offer. Indeed, as Honkasalo (2014) has shown in a study on Finnish men’s suicide notes, this paradox can lead to radical measures. When faced with dependence and hospital care, some men in the study decide to commit suicide due to a moral and cultural injunction that equals the good life with autonomy and independence.

At the same time, as Kaufman (2005) describes, there is a wish for death to be natural. In her study, natural means peaceful and easy. However, for death to be peaceful and easy, it often needs to be facilitated by medicine. The idea of the natural death as the good death has its antecedents in the romantic era of the 19th century, where the good death was described as the beautiful, quiet, painless, disease-free and ordered culmination of a well-ordered life (Cole 1992). When Elie Metchnikoff, one of the founders of gerontology, engaged in this issue in the early 20th century, he believed that the romantic idea of the natural death would soon become common because bacteriology would eliminate infectious diseases, thereby pushing death into old age and ensuring a dignified end to life (1908). Metchnikoff believed that if people merely lived long enough, death would be a peaceful process where the natural instinct for death would substitute the desire to live, and death would thus be the culmination of a life well-lived.

When Fries and Crapo developed the theory of compressed morbidity, the idea of the natural death saw new light (1981). To them, natural death was the inevitable consequence of a linear decline in the functions of the vital organs. These organs would eventually become incapable of defending the body against accidents or diseases, and thus would be unable to sustain life. The enhancement

techniques of modern medicine provide a sense that death is controllable and subject to timing, when, for example, people in their nineties estimate healthy life years left to them in relation to the possibility of complex treatments and surgeries (Kaufman 2010; Clarke 2012). But when timing and control become important characteristics of the good death, the idea of the natural death becomes even more paradoxical.

This paradox is merely one of a series that relates to the good death. Studies have shown that there is a discrepancy between how people describe their ideal death when they are healthy as opposed to when they are experiencing illness. Healthy people are said to prefer a quick death without their experiencing intensive care units that prolong the process of dying, whereas very sick people and their families usually cling to life (Kaufman 2005). This discrepancy is paradoxically inscribed into medical practice: one of the central components of modern medicine is the prolongation of life. While this component has contributed heavily to the increase in average life expectancy, it has also led to a lack of acknowledgement of death as a possible outcome until all treatments have been tried. Death is seldom part of the communication between doctor and patient until every possibility of survival has been ruled out. This causes both long lives and long processes of dying.

However, when death can no longer be postponed, a shift occurs. A new discipline enters – the critical care doctor – and the good death is now facilitated as quick, painless and somehow natural, in the sense that ventilators are removed and the alienation and patientisation is minimised in order to arrange for the family to say their last goodbye in as peaceful a manner as possible. In this sense, death is paradoxically both prolonged by modern medicine and arranged as quick and painless by the same institution.

Critical gerontologist Harry Moody has carved out of this paradox an ageing scenario that he calls the prolongation of morbidity (1995). He states that if the meaning of the good old age is defined by quality of life, then terminating treatment should be more easily accessible. If people actually prolong morbidity through current medicalised death trajectories, then why not choose a death that is more congruent with the ideal many have of a quicker and more painless death? This of course leads to some difficult questions regarding how to decide when euthanasia is acceptable. The prolongation of morbidity is contrary to the compression of morbidity, which through prevention and health promotion programmes aim to extend middle age into old age and eliminate gradual decline. But at the same time, the prolongation and compression of morbidity are both present in the way death is arranged in modern medicine.

In the following sections we explore how enhancement techniques configure this paradox between prolongation and compression of morbidity. We look at en-

hancement techniques as techniques that not only speak to these concepts of morbidity, but also address death as an autonomous and immediate event. However, we explore enhancement as a technique that carries the possibility of a prolongation of death by insisting on improvement and functional progress even in the absolute last phases of life. We refrain from the debate on palliative care, and propose to look at enhancement techniques for older people as illustrative of discourses that pertain to notions of death as an autonomous and immediate event, and thus part and parcel in creating and facilitating the good death.

Adjustment? Adaptation? Continuity? Rehabilitation? How to handle ageing populations

It has long been argued in disability studies that the surge of enhancement technologies in the 20th century has been intrinsically linked to the change in the way disability is understood (Mitchell & Snyder 2004). Henri-Jaques Stiker, and more specifically his work 'A History of Disability', has become synonymous with the notion that disability after World War I came to be seen as an integral part of society (Stiker 1982). Whereas disability had previously been seen as an exceptionality to be handled, most often through exclusionary measures, disability after World War I was primarily handled through programmes of rehabilitation and reintegration (Ingstad & Whyte 1995). Although one could arguably trace the history of enhancement technologies prior to World War I, the argument that rehabilitation and reintegration has been central to the developments of enhancement technologies post-World War I points to the changes in the perception and handling of disability. This can be seen, for instance, in the numerous developments of prosthetics for disabled veterans returning from the European battlegrounds in order to mimic both function and appearance of the removed body part as closely as possible.

Although it is fair to say that many breakthrough innovations on prosthetics, in particular leg prosthetics, were developed after the American Civil War (Yuan 1997), the reintegration of soldiers into civic life after World War I prompted a huge boost to the prosthetics companies, which engaged in copious ordeals in order to create the most functional and inconspicuous prosthetics on the market (Gerber 2003). More direct measures for rehabilitation were also initiated in other areas of society, such as in the arrangement of Petanque playing fields in France, and diagnosis and treatments of shell-shock, among others. These different remedies facilitated rehabilitation and re-entry of veterans into society by making the veteran self-sufficient and thus not a burden on society (Gerber 2003).

The same picture could be said to apply to the prevalent enhancement techniques aimed at treating and managing disabilities in contemporary Western so-

cieties. With the increase in focus on self-sufficiency and autonomy, enhancement techniques have emphasised the applicability of the device/medication by the user him/herself. Thus, many enhancement technologies have been framed as assistive devices designed to create a feeling of 'normality' in its users (Hogle 2005). This notion of normality implies a self-sufficient and autonomous individual.

For the numerous scholars who deal with disability in particular, notions of normality are quintessential in defining a life with disability (Davis 2004, Mitchell & Snyder 2004), and autonomy has figured as an essential part of these notions. As such, there is a strong link between rehabilitation and autonomy in both academic discourse and policy making. One could arguably say that enhancement techniques have figured as a central element in the strengthening of this link. The way disability is handled through enhancement techniques such as rehabilitation programmes concentrate on regaining autonomy and normality.

As we demonstrate, rehabilitation programmes have also become a central part of handling the decline that come with old age in contemporary European welfare states. Loss of autonomy is no longer part of the way old age is shaped. However, this represents a break from the way old age was previously accepted as a period of life wherein the old person should accept the decline and adjust his or her expectations and conduct (Lassen 2014a). In social gerontology, the ideal way to age after retirement was portrayed for a long period of time as an adjustment process in which life satisfaction was best assured if the person no longer expected to be able to perform the same things as earlier in life (Havighurst 1969). In other words, one should adjust personally (Cavan et al. 1949) as well as socially (Pollak 1948). Moreover, the much criticised 'disengagement theory' suggested that individual disengagement from life was beneficial for the individual, who would more easily accept loss of abilities, as well as for society, which would obtain a more fluid labour market because older generations would not cling to jobs that younger generations were more fit for (Cumming & Henry 1961).

While the disengagement theory was abandoned, even by the authors themselves, for portraying a too pessimistic image of old age, the so-called activity theory (Havighurst & Albrecht 1953), which highlighted adjustment to old age, remained central in policy making for decades (Katz 1996). By the end of the 1960s, the continuity theory (Maddox 1968), suggested that old people adapt rather than adjust, that is, employ a range of strategies to be able to continue the same lifestyle as they have had throughout their life trajectory. In the 1980s and 1990s other theories and qualifications of the ageing process, such as successful ageing (Rowe & Kahn 1987) and active ageing (Walker 2002) suggested that ageing is malleable and can be a period of personal reinvention. The adjustment in these theories is not centred on adjustment to a decrease in abilities and functional capacity, but on an adjustment that enables the individual to realise his/her full potential and

engage in life in new ways that are enabled by the fact that most older people are no longer working.

With these shifts in the theories and vocabulary of ageing, decline and death have become more and more peripheral to the way ageing is understood. When ageing becomes malleable, and the normal ageing process is portrayed as one of engagement, participation and independence, decline becomes pathological. The compression of morbidity envisioned by Fries suggests that we should be able to die in a healthy state. It portrays a long healthy life with a quick death at the end. The British historian Peter Laslett has suggested that we can no longer talk of old age as one life phase, but should instead talk about the third and the fourth age, the third age being the long and healthy state after retirement prior to decline, and the fourth age being the last phase of life replete with disease, decline and dependence (1987). In this line of thought, the third age is lived by active and healthy old people who lead lives that are very different from those who are in a process of decline. This, in effect, creates a rather radical rupture between the third and the fourth age that delineates a sharp divide between those who are healthy and those who are not. Thus, one's age group is defined by one's health status, and the last part of life – the fourth age – becomes a period with one overarching characteristic: decline.

As American anthropologist Sarah Lamb recently argued, the cultural-political successful ageing paradigm has had difficulties embracing notions of decline and death. Instead, Lamb opts for a different normative articulation of old age that accepts decline and death as meaningful and integral parts of life. The quest for permanent independence acts counter to what she has found in her fieldwork in India, where dependence on younger kin is seen as part of a lifelong relationship of intergenerational reciprocity (Lamb 2014). While Lamb's examples are American and Indian, the focus on independence seems similar to that which plays out in the realm of European welfare states today. As we demonstrate in the following section, independence is a moral question in Denmark, where individual autonomy is articulated in conjunction with independence from welfare services, making other forms of autonomy, such as choosing dependence, decline or death, immoral. However, the good death is at the same time paradoxically staged as quick and painless, which in practice often becomes impossible when medical practices aim to extend life and postpone death as long as possible.

‘As long as possible’

When the Danish Elderly Commission (*Ældrekommissionen*) stated in 1982 that Danish nursing homes disempowered residents and did not provide sufficient possibilities for them to use their own resources and participate as active agents,

the notion of continuity became a key concept. Continuity was subsequently facilitated through the demolition of old nursing homes and the construction of new small housing for elderly people. 'As long as possible in one's own home' was staged as the mantra for a good life in old age (Ældrekommissionen 1982). Old age was no longer portrayed as a short period of life, but became a long life phase in which people should be able to feel that it is a continuation of life as they had lived it so far. While many old people were still dependent on welfare services, these services moved into people's homes through an expansion of the homecare institution, rather than being provided primarily in nursing homes.

The mantra of 'as long as possible' was repeated by the Homecare Commission appointed by the Danish government in 2012. However, the focus was now on old people remaining independent and unassisted for as long as possible, and to stay 'as long as possible in a *suitable* home' (authors' emphasis) (Hjemmehjælpskommissionen 2013). This involved an increased focus on rehabilitation programmes, which we describe below, as well as a break with the idea that staying at home was necessarily the best quality of life option. The Commission stated that quality of life was greater in assisted living facilities than it was for people with high care needs staying at home. This latter group was also a larger economic burden for the municipalities (Hjemmehjælpskommissionen 2013). As such, the home could now be unsuitable for old people if they no longer possessed basic functional and cognitive capacities.

Moreover, the 2013 report stated that new digital technologies could potentially create higher quality and flexibility in the homecare institutions, but that older people using the technologies had to have the capacity to use them. As such, there is a specific kind of independence at stake, where dependence on technological aids are seen as potentially creating quality of life, whereas dependence on homecare should be avoided for as long as possible. '...welfare technologies can provide smarter and more flexible opportunities for the citizens to be able to handle concrete assignments and thus remain independent from help for longer' (Hjemmehjælpskommissionen 2013). Independence from help is thus implicitly independence from homecare, and is portrayed throughout the report as the relevant form of independence. In other words, welfare technologies provide independence and a potentially higher quality of life, while homecare creates dependence and a potentially lower quality of life.

In the public discourse, 'quality of life' has become associated with independence and autonomy, particularly among the elderly. DaneAge (Ældre Sagen), a very influential Danish non-profit organisation that has approximately 800,000 members (in a country with a population of 5,600,000), conducted a survey on the notion of quality of life, in which it summarises that fears of dependence on others as well as fears of loneliness become increasingly significant in old age (Ældre Sa-

gen 2015). Quality of life has become a key parameter for assessing homecare, and some municipalities use it as their main focus in other areas regarding old people as well. For example, the municipally funded initiative Ældres Netværk (Older People's Network) in the municipality of Ishøj, sees quality of life as their main objective, and defines it as having close and meaningful relations, 'being the pilot of one's life' (independent and self-reliant) and being healthy (Ældres netværk Ishøj 2015). The notion of quality of life has also increasingly become standardised and numerous studies have – through quantitative methods – researched quality of life in old age based on a mix of objective and subjective measures (Rostgaard et al. 2012).

Following the same focus on quality of life, new standards of measurement have been created. Quality adjusted life years (QALY) measures the outcomes of specific health interventions on both the number of years it potentially adds to the life of the person involved, as well as on the quality of these years assessed through 'objective' health measures, i.e. the ability to walk etc., and according to their economic costs (Puma 1990; Juel et al. 2006). To that effect, this measure adds an economic and utilitarian dimension to the debate. Based on numbers from the National Patient Registry, the Danish Regions, an organisation representing the five regions in Denmark, published an analysis in 2014 that showed that the amount of hip, knee, heart-valve and cataract surgeries had risen by 44% from 2007–2013 among people above the age of 65. According to an article subsequently published by Danish Regions, the rise was due to the development of new methods such as less invasive methods of surgery as well as 'the accelerated surgical program' (Kehlet 2001) that aims to reduce both the risks associated with surgeries among elderly and the length of hospitalisation. As such, the increasing number of surgeries in old age seems to be associated both with utilitarian measures as well as a focus on quality of life and autonomy in old age. Moreover, this rapid increase suggests that people are expecting to live longer, and that the last years of life should be characterised by independence and quality of life rather than by slow decline and decay.

As Clarke et al. argue, research on the experience of living in a dying body has received only scant attention in gerontological studies (Clarke et al. 2012). In general, the focus in these studies is on successful ageing, which overshadows living experiences that are somewhat incompatible with the notion of successful ageing (Bülow 2014). When James Fries introduced the theory of compression of morbidity, he also introduced a specific kind of human enhancement where we could all die healthily when we reached our maximum lifespan (1980). Thus, the compression of morbidity highlights not only the good life for the elderly, but the good death for the elderly, i.e., one in which the process of dying has been limited to a minimum. While surgeries in old age represent a set of enhancement technologies that attempt to facilitate this death, rehabilitation programmes mix a

range of enhancement technologies with an injunction to re-appropriate an active lifestyle physically and socially – which we call enhancement techniques.

Rehabilitation programmes have become more widespread in Denmark in the past decade. From January 2015, they have been deemed statutory as a necessity to be assessed by homecare institutions. These programmes emphasise enabling old people to find their inner motivation to engage in activities that help them regain functional capacity. Whereas assessment for homecare until the 2010s in Denmark was conducted according to the needs of the individual, these needs today are negotiable and conditioned by the individual's motivation to rehabilitate. When a person approaches the municipality in which he/she lives in order to obtain homecare, he/she must first undergo a rehabilitation programme, unless those assessing an individual's request for homecare conclude that this is impossible. This assessment of whether or not the person is able to attend to the activities of daily living without the help of municipal care workers is based on the possibility of the rehabilitation of functional capacity and/or the introduction of different kinds of assisted living.

A simple device such as an aid that helps the old person put on his/her compression stockings² in the morning and take them off in the evening is often highlighted as an example of the way a device can both increase quality of life through the rehabilitation of an ability and save public expenditures on homecare. Before the use of this aid, the person reliant on compression stockings would not be able to get up in the morning before the home care assistant had come to assist with the compression stockings. Likewise, the person would not be able to go to bed before they were taken off. Because the device enables the person to put the stockings on and take them off, it forms part of a rehabilitation programme. Thus, rehabilitation programmes are not solely focused on physical training, although this is often the case, but on different ways to create independence from welfare services.

With rehabilitation programmes, the person is supported in his or her sustaining a healthy and functional body for as long as possible (Socialstyrelsen 2014) until a short process of morbidity prior to death can no longer be postponed. Originally, Fredericia, the municipality that first introduced rehabilitation in Denmark, framed its rehabilitation programme as a one of empowerment. This meant that individual rehabilitation programmes should be based on the person's own motivations and subjective objectives for the process. Fredericia later developed the programme 'as long as possible in one's own life', where rehabilitation is central (Fredericia Kommune 2012). With the emphasis on 'one's own life', the scope expands to the idea that the home (which means that which is not a nursing home) might not always be the suitable residence for the old person. The goal is not residential continuity, but continuity of independence (Fredericia Kommune 2012). In this light, decline is not seen as a hindrance to quality of life. It is the ability to

‘create one’s own day’ that provides quality of life. With the ‘as long as possible in one’s own life’ programme, the municipality attempts to create active and participating people who can master decline (Fredericia Kommune 2012).

As we have seen, decline can be embraced in rehabilitation programmes. But the lingo of mastering, independence and motivation seems incompatible with death, which is absent in the enhancement techniques of rehabilitation policies. Paradoxically, death seems to be so peripheral to the current focus on rehabilitation that some municipalities can only provide accommodation for their dying citizens in rehabilitation units³.

Conclusion

It is through the absence of death that the idea of death embedded in rehabilitation reveals itself. Rehabilitation turns decline in old age into a question of motivation and life conduct. When the person’s functional capacity is linked to motivation, it becomes a moral question whether he or she can rehabilitate. The rehabilitation staff is trained to nurse the ‘inner motivation’ of old people, and as motivation is seen as something that must be somehow inherent in the person, lack of motivation is not so much a failure of the staff as it is an immoral choice of the person who refuses to be motivated to rehabilitate.

Following this line of thought, death is at the end of a long old age, when a person might have faced problems with diseases, falls and accidents, but has recovered again and again, regained functional capacity and continued to live because of his or her motivation and ability. The notion is implicit: if one stops rehabilitation and refuses to be active, if one sits on the couch and stops engaging in the activities of daily living, death comes quickly. Human enhancement is dependent on a technique of constant motivation and recovery. The old body incapable of rehabilitation has exhausted every remedy, and ceases to be functional, healthy and active.

There would seem to be a dual process going on when enhancement techniques such as rehabilitation and surgeries in old age become an important tool for the management of care by the welfare state. On the one hand, while these techniques are essential in the governance of a normative notion of the management of life and death, they are also continuously changing the definitions of normativity. This becomes increasingly obvious with the changes in what is discursively presented as autonomous with the implementation of new enhancement techniques. When one does not take advantage of these techniques, it is implied that one refuses autonomy; in doing so, one becomes a burden on the welfare state.

Enhancement techniques have become an essential part of managing as well as orchestrating death. This article has proposed that the recent increase in enhan-

cement techniques has been caused in particular by the discursive link between these techniques and the notion of autonomy. Through an analysis of the notion of the good death in the Danish welfare state, we argue that rather than promoting autonomy in terms of choosing one's own death, enhancement techniques are increasingly becoming infused with a moral dimension that makes the choice of being subjected to them less of a choice and more of an imperative. Subjected to such an imperative, we ask: what does autonomy mean if not the right to choose one's own death?

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Notes

¹ For her last words, see her blog Bovering Books 2015

² Compression stockings help to prevent blood clots for high-risk groups. It is seen as risky for the users to get up in the morning without them and to go to bed wearing them.

³ See for example Frederikssund Kommune 2015.

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